

## **REQUEST TO AMEND OR LIMIT PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address where you want the amendment response sent:

\_\_\_\_\_

**NOTICE TO PATIENT:** Your request to amend or limit your protected health information (such as health records, name, address, and social security number), in any form **only** applies to the information maintained by the Alabama Department of Public Health (hereinafter “ADPH”). If you would like to request amendments or limits to your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider.

### **REQUESTED AMENDMENT:**

I request that ADPH amend or limit (describe the information you would like amended or restricted):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request the amendment or limitations described above to be made to the protected health information in my designated record set (medical record) maintained or created by ADPH. Date of record or information you would like to amend or limit:

\_\_\_\_\_

I would like this information amended or limited because (state specific reason for request):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FOR AMENDMENTS:** I am attaching proof that my record should be amended because it is false, inaccurate or incomplete.

**PLEASE NOTE: No form will be considered unless you provide sufficient proof that the record that you intend to be amended is false, inaccurate, or incomplete.** *[An example of an appropriate attachment would be your birth certificate to prove that the date of birth in your file is wrong]*

\_\_\_\_\_  
[Signature/Title, if legal representative\*]

\_\_\_\_\_  
Date

\*May be requested to submit evidence of representative status.

**REQUEST APPROVED:**

If ADPH approves your request to amend or limit the release of your record, please complete the attached form (FORM D), and return it to us, to identify any persons or entities that we need to notify of the amendment or limitation to your protected health information.

**REQUEST DENIED:**

By: \_\_\_\_\_  
Signature Title Date

**Reason for Denial:**

- The information was not created by ADPH.
- The information is not part of your Designated Record Set.
- The information is not available for your inspection pursuant to the ADPH's Policy regarding individual access because \_\_\_\_\_.
- The information is accurate and complete.

If your request for an amendment or limitation to your protected health information is denied, you may submit a written statement of your disagreement with the denial. Send the statement of disagreement to:

Privacy Officer  
Alabama Department of Public Health  
201 Monroe Street, Suite 785  
Montgomery, AL 36104  
(334) 206-2648

After submitting your disagreement in writing, you will be given an opportunity for a hearing on why your request was denied. You will receive sufficient notice of the time and place that the hearing will be held.

\*\*\*\*\*Retain for minimum of 6 years\*\*\*\*\*